UPSTATE
UNIVERSITY HEALTH SYSTEM

Release of Information Authorization Form

I authorize the use/disclosure of health information about me as described below.

1. Who is releasing the information: [Practice Name or Provider here]

_____

2. Who would you like to receive the information:

_____

3. Description of information that may be used/disclosed:

_____

_____

_____

4. The information will be used/disclosed for the following purposes:

_____

_____

5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.
6. I understand that the practice may receive compensation for its use/disclosure of the information.
7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization. **(Note: This item is not required if the disclosure is requested by the patient.)**
8. I understand that I may revoke this authorization in writing at any time by submitting documentation to the practice except to the extent that action has been taken in reliance on this authorization. This authorization expires one year from the date signed unless otherwise directed.

_____ _____

Signature of Patient or Representative | Date

_____ _____

Patient's Name | Date of Birth

_____ _____

Name of Personal Representative (if applicable) | Relationship to Patient